STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155673	A. BUILDING 00 B. WING	06/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKLE HEALTH & REHABILITATION	170 N TRACY ST MARKLE, IN46770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey Survey dates: June 13, 14, 15, 16, and 17, 2011 Facility number: 000544 Provider number: 155673 AIM number: 100267340 Survey team: Vicki Bickel, RN-TC (June 13, 15, 16, and 17, 2011) Debora Barth, RN (June 13, 15, 16, and 17, 2011) Kim Davis, RN Census bed type: SNF/NF: 66 Total: 66 Census payor type: Medicare: 5 Medicaid: 43 Other: 18 Total: 66 Sample: 15 Supplemental sample: 3 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed 6/24/11 by Jennie Bartelt, RN.			
F0223 SS=A	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to prevent staff from using derogatory language about a resident (Resident #52) within hearing distance of the resident for 1 of 3 residents reviewed for abuse in a supplemental sample of 3. Findings include: Resident # 52's record was reviewed on 6/17/11 at 9:15 a.m. The record indicated diagnoses included, but were not limited to: osteoarthritis, hypertension, dementia with delusions, and dementia with behavioral symptoms. On 2/18/11 Physical Therapy Assistant was overheard, by the Administrator, telling a certified nursing assistant that	F0223	F223- Abuse- Staff Treatment of ResidentsIt is the practice of this provider that all residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals. It is also the practice of this provider that each resident has the right to be free from mistreatment, neglect and misappropriation of funds. I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident #52 experienced no negative physical or emotional outcome as a result of this finding. The employee identified in this finding	07/17/2011

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	Resident #24 smelled of "s---." The PTA was suspended immediately, pending investigation and terminated on 2/22/11, as per facility policy. The resident was observed for any psychosocial distress with no signs or symptoms of distress per social service notes dated 3/1/11. The incident was reported to ISDH (Indiana State Department of Health) and other various agencies on 2/18/11 with the follow-up reported on 2/22/11 per ISDH regulations and facility protocol. The Administrator was interviewed on 6/16/11 at 10:20 a.m. to review the abuse policies and procedures. She indicated the employee had been terminated according to the facility policy. 3.1-27(b)		is no longer employed at this facility. II. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents are at risk to be affected by this finding.Any allegation or statement regarding resident abuse or mistreatment will be reported immediately to the Administrator and DNS. The facility will immediately initiate a full investigation as well as ensure notification to the MD, the family, ISDH, and other agencies as outlined in the facility policy. Appropriate disciplinary action including suspension and possible termination of employment will be a consideration for any staff member involved in a substantiated allegation of abuse toward a resident. III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?An all staff in-service will be held by 7/15/2011 & conducted by DNS/designee. This in-service will include review of the facility policy and procedure regarding Abuse Prohibition, Reporting, and Investigation. Any allegation or statement regarding resident abuse or mistreatment will be reported immediately to the Administrator and DNS. The facility will immediately initiate a full investigation as well as	

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			ensure notification to the MD, family, ISDH, and other agencies as outlined in the facility policy.IV. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what Quality Assurance Program will be put into place?The DNS or other designee will be responsible for completion of the CQI Audit Tool titled, "Abuse Prohibition and Investigation" and "Abuse" weekly X4, monthly X3, and then quarterly thereafter to monitor for ongoing compliance. Any trends or findings will be submitted to the CQI Committee for review and follow-up. Compliance Date: 7-17-11	
F0224 SS=A	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to prevent neglect for 1 of 1 resident (Resident # 24) in a sample of 15 who was left unattended on the toilet for an extended period of time. Findings include: Resident # 24's clinical record was reviewed on 6/17/11 at 10:20 a.m. The record indicated diagnoses included, but were not limited to: diabetes mellitus, congestive heart failure, hypertension, chronic renal failure, peripheral vascular	F0224	F224- Abuse- Staff Treatment of ResidentsIt is the practice of this provider that all residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals. It is also the practice of this provider that each resident has the right to be free from mistreatment, neglect and misappropriation of funds. I. What corrective action(s) will be accomplished for those residents found to have been affected by	07/17/2011

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	disease, severe dementia and depression. On 5/26/11 CNA #3 was asked by the nurse to toilet Resident #24 at approximately 11:25 a.m. The CNA assisted the resident to the toilet, placed an alarm that would sound if he attempted to get up from the toilet and then left him unattended sitting on the toilet. The resident was found sitting on the toilet at approximately 12:15 P.M. by another CNA. The resident's skin was assessed with no issues noted and the resident was monitored for psychosocial distress. The resident had no memory of the incident per the incident report dated 5/27/11 and signed by the Director of Nursing Services. The CNA was suspended, pending investigation and terminated on 5/27/11, per facility policy, for passive neglect and gross carelessness. The incident and follow-up were reported to ISDH (Indiana State Department of Health) and other various agencies on 5/27/11 per ISDH regulations and facility protocol. The Administrator was interviewed on 6/16/11 at 10:20 a.m. to review the abuse		the deficient practice?Resident #24 experienced no negative physical or emotional outcome as a result of this finding. The employee identified in this finding is no longer employed at this facility. II. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents are at risk to be affected by this finding.Any allegation or statement regarding resident abuse or mistreatment will be reported immediately to the Administrator and DNS. The facility will immediately initiate a full investigation as well as ensure notification to the MD, the family, ISDH, and other agencies as outlined in the facility policy. Appropriate disciplinary action including suspension and possible termination of the employment will be a consideration for any staff member involved in a substantiated allegation of abuse toward a resident. III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?An all staff in-service will be held by 7/15/2011 & conducted by the DNS/designee. This in-service will include review of the facility policy and procedure regarding Abuse Prohibition, Reporting, and Investigation. Any allegation or statement regarding resident	

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	policies and procedures. She indicated the employee had been terminated according to the facility policy. 3.1-27(a)(3)		abuse or mistreatment will be reported immediately to the Administrator and DNS. The facility will immediately initiate a full investigation as well as ensure notification to the MD, family, ISDH, and other agencies as outlined in the facility policy.IV. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what Quality Assurance Program will be put into place?The DNS or other designee will be responsible for completion of the CQI Audit Tool titled, "Abuse Prohibition and Investigation" and "Abuse" weekly X4, monthly X3, and then quarterly thereafter to monitor for ongoing compliance. Any trends or findings will be submitted to the CQI Committee for review and follow-up. Compliance Date: 7-17-11	
F0248 SS=D	The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.			
	Based on observation, interview, and record review, the facility failed to ensure the activity needs were met for 1 of 1 resident reviewed for activities in a total sample of 15 (Resident # 32). Findings include : The "Cottage " Activity Calendar included	F0248	F248 - ActivitiesIt is the practice of this facility to provide an ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident.I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident #32 is	07/17/2011

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	the following for June 13 through June 15, 2011. June 13 : 7: 00 a.m. - Breakfast, 8:00 a.m. - Clean up and relaxation, 10:00 a.m. - Balloon bat, 10:30 a.m. - Juice and coffee, 11:00 a.m.- Freshin' up, 11:15 a.m. - Lunch, 12:00 p.m. - Clean up and relaxation, 1:00 p.m. - Baking/snack, 3:00 p.m. - Club time, 4:00 p.m. - Today is, 4:30 p.m. - Freshin' up, 5:00 p.m. - Supper, 6:00 p.m. - Reminisce June 14 : 7: 00 a.m. - Breakfast, 8:00 a.m. - Clean up and relaxation, 10:00 a.m. - Kick ball, 10:30 a.m. - Juice and coffee, 11:00 a.m.- Freshin' up, 11:15 a.m. - Lunch, 12:00 p.m. - Clean up and relaxation, 1:00 p.m. - Coloring, 3:00 p.m. - Craft, 4:00 p.m. - Devotion, 4:30 p.m. - Freshin' up, 5:00 p.m. - Supper, 6:00 p.m. - Reminisce June 15 : 7: 00 a.m. - Breakfast, 8:00 a.m. - Clean up and relaxation, 10:00 a.m. -Balloon bat, 10:30 a.m. - Juice and coffee, 11:00 a.m.- Freshin' up, 11:15 a.m. - Lunch, 12:00 p.m. - Clean up and relaxation, 1:00 p.m. - Baking and snack, 3:00 p.m. - Craft, 4:00 p.m. - Today is, 4:30 p.m. - Freshin' up, 5:00 p.m. - Supper, 6:00 p.m. - Reminisce The following observations were made of		receiving one-on-one visits and this is being documented on the Individual Programming Participation Record.The activity care plan has been updated for resident #32.An updated activity progress note has been written for resident #32.II. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents are at risk to be affected by this finding.An audit will be performed on all residents to ensure that activity care plans are present and are an accurate reflection of the resident. An audit will also be performed on all residents to ensure that activity progress notes are current and present for all residents.All residents requiring 1 on 1 visits will be reviewed for accuracy and a new revised list will be generated for those residents needing 1 on 1's.III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?Activity personnel will be re-educated on 1 on 1's, timeliness & completion of progress notes & on timely completion of care plans that are an accurate reflection of the resident. Re-education will be completed by 7-15-11 & conducted by SDC/designee. Activity personnel will keep a record of residents invited and if they accepted or declined.	

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	Resident # 32 in her recliner in her room: June 13, 2011: 9:50 a.m. - 10:30 a.m., 12:00 p.m. - 1:00 p.m., 2:00 p.m. - 3:30 p.m., and 5:15 p.m. - 6:30 p.m. June 14, 2011 : 7:30 a.m.- 8:00 a.m., 9:30 a.m. - 11:00 a.m., 12:40 p.m.- 1:45 p.m. June 15, 2011 : 8:15 a.m. - 11:00 a.m., 12:45 p.m.- 3:30 p.m. The initial tour was conducted on June 13, 2011 with LPN #1. During the tour, Resident # 32 was observed sitting in the recliner in her room, sleeping. The resident's room was close to the nursing station and activity/dining area. The clinical record of Resident # 32 was reviewed on 6/15/11 at 9:15 a.m. The record indicated the resident's diagnoses included, but were not limited to, mood disorder, depression, and anxiety. The annual Minimum Data Set Assessment (MDS), dated 3/12/11, indicated Resident # 32 required staff assistance for transfer and ambulation. The MDS indicated the resident enjoyed books, newspapers, music, animals, the outside, church, and to be with groups of people. The "Cottage care plan" dated 5/31/11 indicated the resident's family should be encouraged to visit, encourage		Memory Care Coordinator will review this record each week to ensure all residents are offered the opportunity to participate.IV. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what Quality Assurance Program will be put into place?Facility management personnel will be responsible to complete a CQI Audit Tool titled "Activities". Completion of this audit tool will be performed weekly x 4 weeks & then monthly x 3 months. CQI Committee will then re-evaluate the need for continuation. Any trends or findings will be submitted to the CQI Committee for review and follow-up.Compliance Date: 7-17-11	

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	socialization, and the resident loved cats, news, and conversing. There was no activity care plan in the clinical record. There were no Activity Progress notes in the resident's clinical record. When interviewed on 6/16/11 at 9:30 a.m., Activity Director # 2 indicated she had taken the activity notes from the clinical record so she could make an entry. She indicated Resident # 32 was in her room all week. She indicated the resident did not go on the outing on 6/13/11 or to the devotions on 6/14/11. The activity director further indicated the resident did not receive one to one visits for stimulation. She indicated she had no record of spending time with the resident. There were two entries made in the Activity Progress notes, one dated 1/14/11 and one dated 3/4/11. The notes were presented on 6/17/11 at 8:30 a.m. by Activity Director # 2. She had added a note dated 6/16/11 and a one to one care plan was added, dated 6/16/11. 3.1-33(a)			

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F0253 SS=E	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to assure the cold air return vents in the hallways were kept clean and dust-free. The deficient practice affected 56 of 66 residents. Findings include: The environmental tour was conducted on 6/15/11 from 1:00 p.m. to 2:20 p.m. with the Maintenance Supervisor. The following observations were completed: The cold air return vent cover on the 200 hall had a heavy accumulation of dust, giving the white vent a gray appearance. The cold air return vent cover on the 100 hall had a heavy accumulation of dust on it, giving the white vent a gray appearance. The cold air return vent cover on the 300 hall had a heavy accumulation of dust on it, giving the white vent a gray appearance. The cold air return vent cover on the hallway leading to the Main Dining Room had a heavy accumulation of dust on it, giving the white vent cover a gray appearance. The Maintenance Supervisor, during	F0253	F253 - EnvironmentIt is the practice of this facility to maintain housekeeping and maintenances services in a sanitary, orderly, and comfortable interior.I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?The cold air return vents in the hallways were immediately cleaned of dust.II. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All air vents in the facility have the potential to be affected by this practice.Maintenance supervisor completed a visual audit of all hallway vents to determine the need for cleaning of additional vents. All hallway vents have been cleaned by housekeeping personnel. III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?Hallway Vent Cleaning was added to the Cleaning Guidelines. Re-education will be completed by 7-15-11 & conducted by the Maintenance Supervisor.IV. How will the corrective action(s) be monitored to ensure the deficient	07/17/2011

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	interivew on the environmental tour, indicated the vent covers were to be dusted daily. 3.1-19(f)		practice will not recur, i.e. what Quality Assurance Program will be put into place?Maintenance supervisor will monitor compliance by completion of a Quality Control Inspection-Housekeeping form. Form will be completed daily x 30 days, weekly x 4 and monthly thereafter. After 90 days, CQI will re-evaluate to determine the need for continuation. Trends will be reported to the C.Q.I. committee for review.Completion Date: 7-17-11	
F0323 SS=E	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to maintain water temperatures at a hand-washing sink in 1 of 4 resident rooms, checked during the environmental tour, and in 1 of three shower rooms at a safe temperature below 120 degrees Fahrenheit (F). This potentially affected 16 residents living on the 300 hall of the 66 residents living in the facility. Findings include: 1. The hand-washing sink in Room 300 was checked for water temperature during the environmental tour conducted from 1:00 to 2:20 p.m. on 6/15/11. The room	F0323	F323-AccidentsIt is the practice of the facility to ensure the resident environment remains as free of accident hazards as possible, including water temperatures.I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?The mixing valve which serves the 300 hall shower room and resident room 300 was changed on 6/29/2011. The water temperatures are testing within the acceptable range of 110-120 degrees. II. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All resident rooms and shower areas have the potential for being	07/17/2011

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	was not occupied at the time. The water temperature registered 128 degrees F on the thermometer of the Maintenance Supervisor. Review of the "Daily Water Temperatures" form for May 2011 indicated the water temperature for Room 300 had most recently been checked on 5/2/11. The temperature had registered 116 degrees F. on that day. The sink water in Room 307 was checked on 5/11/11 and registered a temperature of 117 degrees F. The Maintenance Supervisor indicated, during interview on the environmental tour, the Shower Room on the 300 hall and Rooms 300-307 were all on the same mixing valve from the water heater serving the 300 hall. 2. The shower water temperature in the 300 hall shower room was also checked during the environmental tour. The water registered a temperature of 128 degrees F. The shower room was not included on the "Daily Water Temperature" form. During the interview on the environmental tour, the Maintenance Supervisor indicated this was because CNAs assisted residents with showers and would adjust the water temperature as necessary.		affected by this finding.Maintenance personnel checked the water temperatures in all resident rooms and shower rooms and determined that the water temps were within normal range. Any rooms found to have water temps testing above the acceptable range will immediately be evaluated for the cause. If a faulty mixing valve is determined to be the cause, then the mixing valve will immediately be replaced with a new one.III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?Maintenance personnel will re-educate staff about reporting water temperatures which fluctuate or seem to be elevated. Re-education will be completed by 7-15-11. Maintenance personnel will take & record the water temperatures for all resident rooms & shower areas 2X each weekday x 4 weeks and then 1X each weekday x 4 weeks to ensure compliance. Thereafter, water temperatures, throughout the resident care areas, will be taken and recorded 1 x each weekday, with rooms being randomly selected. This random selection will include a minimum of 3 resident care areas on each hallway. All rooms will be tested no less than monthly. Temperatures will be recorded on the Daily Water Temperatures	

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	3.1-45(a)(1)		Log. Any elevated temperatures found will be immediately reported to maintenance personnel & corrected. IV. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what Quality Assurance Program will be put into place?Maintenance director or other designee will be responsible for completion of a CQI Audit Tool titled "Facility, Enrironmental Review" weekly X 3 months & monthly thereafter to monitor for ongoing compliance. Any trends or findings will be submitted to the CQI Committee for review and follow-up. Compliance Date: 7-17-11	
F0371 SS=E	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure the sanitary condition of the vents, lights and window blinds in the food prep and service areas of the kitchen. In addition, the facility failed to ensure 2 of 2 boxes of thickened liquids, used by nursing staff while passing medications, and stored in the Food Pantry, were dated after opening to ensure an expiration date. The facility also failed to ensure the professional popcorn popper was kept clean for 43 of 66 residents using the common area	F0371	F371 - Sanitary ConditionsIt is the practice of this facility to store, prepare, distribute, and serve food under sanitary conditions.I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?The ceiling vents, lights and window blinds in the food prep & service areas of the kitchen have been cleaned. Both boxes of thickened liquids in the Food Pantry were discarded. The professional popcorn popper was cleaned. The portable table/tv tray was cleaned. II. How will you identify other residents	07/17/2011

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	Activity Room. The facility also failed to ensure the cleanliness of a portable table used for dining by 1 of 23 residents observed at meal time on the secured unit. (Resident # 43). Findings include: 1. A. The dietary sanitation tour was completed on 6/16/11 at 10:00 a.m. with the dietary manager (DM). Four steel, round, ceiling vents were observed over the food prep and service areas. All four were observed to have brown stain covering them. The DM was interviewed and the cleaning schedule reviewed on 6/16/11 at 10:30 a.m. The DM indicated the ceiling vents were not included on the cleaning the cleaning schedule so she did not know when they were last cleaned. 1. B. There were ten, boxed, rectangular light fixtures in the kitchen ceiling. The outside rims of all ten were covered with brown splotchy stains. The DM was interviewed and the cleaning schedule reviewed on 6/16/11 at 10:30 a.m. The DM indicated the ceiling lights were not included on the cleaning schedule, so she did not know when they were last cleaned.		having the potential to be affected by the same deficient practice and what corrective action will be taken?All vents, lights and window blinds & portable tables have the potential to affected by this same deficient practice.The vents, ceiling lights, and window blinds have all been added to the dietary Monthly Cleaning Schedule. Residents no longer use the portable table/tv tray and it has been removed from the cottage. All boxes of thickened liquid were checked for expiration dates and discarded if indicated. Dietary is now attaching a label to the unopened boxes of thickened liquid & the person opening the box will document the date opened on this label.III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?Dietary staff will be re-educated on sanitation including cleaning the vents, ceiling lights and window blinds. Re-education will take place by 7-15-11 & conducted by the facility dietician. Nursing staff will be re-educated regarding the need to place a date on the thickened liquid when opening up a new box. Re-education will be conducted by SDC prior to 7-15-11. Dietary will check the nurses pantry on a daily basis & check for the presence of a date on the opened boxes of thickened liquid and immediately discard any items found to be undated.	

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	1. C. A large vent was on the kitchen wall below the handwashing sink. The grill of the vent was covered in brown dust. The DM was interviewed and the cleaning schedule reviewed on 6/16/11 at 10:30 a.m. The wall vent was not included on the cleaning schedule. The DM indicated she thought the maintenance man would have to remove the grill to clean it. 1. D. There was a window between two freezers in the back of the kitchen. The blind was covered with gray dust. The DM was interviewed and the cleaning schedule reviewed on 6/16/11 at 10:30 a.m. The window blinds were not included on the cleaning schedule. The DM did not know when they were last cleaned.		Dietary will initial a log each day time they check the pantry for items.Activities staff will inspect the professional popcorn popper daily for any cleaning need. Activities staff will clean inside & outside the machine immediately after each use & document on the "Popcorn Machine Cleaning/Inspection Log".IV. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what Quality Assurance Program will be put into place?Dietician will monitor compliance of monthly cleaning of the vents, ceiling lights and window blinds & for the presence of undated/expired thickened liquid in the nurses pantry during her routine visits to the facility. Monitoring will be done 2 x monthly & documented on the Safety and Sanitation Review form. A copy of this documentation will be provided to the facility Administrator and dietary manager & also will be reviewed during the monthly QCI meetings. Maintenance/Housekeeping Supervisor will monitor the popcorn popper for compliance with cleanliness during random spot checks. Maintenance will document results on a CQI audit tool weekly x 4 and monthly x 2. After 90 days, CQI committee will re-evaluate to determine the need for continuation.Trends will be	

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			reported to the CQI committee for follow-up.Compliance Date: 7-17-11	

2. The Food Pantry was observed during the environmental tour on 6/15/11 from 1:00 p.m. to 2:20 p.m. Two of 2 boxes of thickened liquid were dated on 6/2/11 with permanent marker. The labels printed on both boxes indicated the liquids should be used "within 5 days of opening." No other dates were on the box.

The Administrator indicated, on 6/17/11 at 9:30 a.m., that she had interviewed a nurse and the boxes had both been opened on 6/15/11. She also indicated the marked date on the boxes had been put there when the thickened liquids had been delivered to the kitchen by the supplier. There was no indication on the box as to when the boxes were opened, only the marked date of delivery; therefore, there was no way to know when the drinks expired.

3. The environmental tour was conducted on 6/15/11 from 1:00 p.m. to 2:20 p.m. The common Activity Room, located on the 200 hallway, was observed to have a professional popcorn popper with glass doors. The popping box had kernels of popped corn still in it. There was also a crusty sticky residue on the top of the popping box. There was salt and popcorn

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	hulls scattered over the bottom of the collection area. The Activity Assistant indicated, on 6/17/11 at 9:00 a.m., the popper had been used on Monday, 6/13/11. 4. The activity staff and residents on the "Cottage" unit were observed making and eating chocolate cupcakes on 6/13/11 at 3:00 p.m. The evening meal was observed on 6/13/11 between 5:15 p.m. and 6:15 p.m. At 5:35 p.m., Activity Director # 2 assisted Resident # 43 into a chair in the TV lounge area of the Cottage adjacent to the dining area. The Activity Director pushed a small white portable table up to the resident and served her dinner plate of green beans, mashed potatoes, and Salisbury steak with gravy, a small plate with bread and butter, a small plate with a cookie, and glasses of milk, iced tea, and red punch on top of the tray. The tray was observed to have black and brown food substance along the edge of the table closest to the resident. Resident # 43 began to eat her green beans and Salisbury steak with her fingers. She picked up green beans, and ran her fingers along the edge of the table where the food substance was stuck to the table. The resident then put the food into			

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	her mouth. The resident spilled a glass of red punch on the table. The resident was observed from 5:35 p.m. to 6:00 p.m. Staff were not observed to intervene or to assist the resident during the meal. On 6/15/11 at 9:00 a.m., Activity Director # 1 pulled the white portable table from the TV lounge. The Activity Director indicated the table was very dirty and stained, went to the kitchen area for a wet rag, and scrubbed the table clean. When interviewed, on 6/15/11 at 9:05 a.m., the Activity Director indicated the brown food substance still on the side of the table was from the chocolate cupcakes eaten two days prior on 6/13/11. The Housekeeper # 5 was interviewed on 6/15/11 at 1:05 p.m. The housekeeper indicated it was not her job to wash the portable table. 3.1-21(i)(3)			

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to ensure the June 2011 physician rewrites were correct prior to the physician's signature for 1 of 15 residents medication orders reviewed in a sample of 15 (Resident # 37). Findings include: The clinical record of Resident # 37 was reviewed on 6/17/11 at 9:00 a.m. The record indicated the resident's diagnoses included, but were not limited to, gastritis, anemia, heart disease, and dementia. A telephone order dated and signed by the physician on 5/31/11 indicated, " D/C (discontinue) Aggrenox. D/C Potassium Chloride. D/C Lisinopril. D/C Namenda. D/C Vitamin. D/C Ferrous Sulfate"." The current Physican rewrites, signed by	F0514	F514- Clinical RecordsIt is the practice of this provider to maintain accurate, complete, and organized clinical information about each resident that is readily accesible for resident care.I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident #37 experienced no negative outcome as a result of this finding. Resident #37 clinical record has been corrected and accurately reflects this resident's current medications. The physician was made aware of this error on the June Physician Rewrites.II. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents are at risk to be affected by this finding and will be indentified through a facility audit. This audit will include a review of all resident charts to ensure	07/17/2011

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	the doctor on 6/5/11, indicated, "... Aggrenox 25-200 mg (milligrams), Pot Chloride (Potassium Chloride) 10 meq (millequvilents), Lisinopril 2.5 mg, Namenda 10 mg, High Potency Vits (vitamins) & Minerals, Ferrous Sulf (sulfate) 220 mg...". The June 2011 Medication Administration Record (MAR) was reviewed. The medication were highlighted as discontinued on 6/1/11. LPN # 1 was interviewed on 6/16/11 at 8:40 a.m. The nurse indicated the medications were discontinued by the physician on his 5/31/11 visit. She indicated the medications should have been taken off the June rewrites before the doctor signed as current on 6/5/11. 3.1-50(a)(2)		physician orders have been accurately transcribed and accurately noted on the most recent Physician Rewrite. Any discrepancies will be corrected and clarified when identified. The Nurse Management Team is responsible for completion of this audit. In addition, the Nurse Management Team is responsible for daily review of all Physician Orders. This review includes checking that all orders have been accurately transcribed onto the MAR/TAR and onto the current Physician Rewrite Orders.III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?An all nursing staff in-service will be held by 7/15/2011 & conducted by the DNS/designee. This in-service will include review of the facility process for physician order transcription, including updates to the current Physician Rewrite to accurately reflect each resident's current medication list and physician orders. This in-service will also include review of the facility monthly Rewrite process to ensure all physician's orders are accurately transcribed and correctly noted on each monthly Rewrite.IV. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what Quality Assurance Program will be put into place?The DNS and/or designee	

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			will be responsible for completion of the CQI Tool titled, "24 Hour Condition Report Review" weekly x 4 and then monthly thereafter to ensure ongoing compliance. Any findings will be submitted to the CQI Committee for review and follow-up.Compliance Date: 7-17-11	